Mental Retardation and Developmental Disabilities Administration
Department of Human Services
Government of the District of Columbia

DHS Form 1209-W:
Annual ISP/IHP Medicaid Waiver Recertification

(for Codes 873, 873Q, 873S)

Please complete, sign, and fax to the IMA Medicaid Branch

Last Name	First Name	Middle		Telephone (Home)	
Address Where You Live	Street		City	State	Zip
Mailing Address (if different)	Street		City	State	Zip
Social Security Number	Date of Birth	Sex	ACEDS Case # (if available)		

1. Have you completed a recent level-of-care assessment? ❑ Yes ❑ No
2. Do you currently receive SSI? (if YES, stop here, sign and return) ❑ Yes ❑ No
3. Are you still a District resident? ❑ Yes ❑ No
4. Is your income still below the special income limit* for the Waiver? ❑ Yes ❑ No
   * 300% of the SSI payment level
5. Are your countable resources still below the categorically needy level? ❑ Yes ❑ No
6. Do you receive Medicare? If so, provide Medicare # or copy of card. ❑ Yes ❑ No
7. Please describe below any changes in your household or circumstances.

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Signature of Authorized Representative Date